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Dr. M. G. Candau and W.H.O.

In July of this year Dr. M. G. Candau retires from the World Health Organization after having been its director-general for 20 years. The ideals and objectives of which the Organization is the tangible expression have always found support in Britain, and British doctors have played an important part in the development of the W.H.O.'s technical activities whether as members of the staff, consultants, or participants in the numerous small meetings of experts convened for the discussion of specific problems. If in the past 20 years the W.H.O. has been able to win such strong support from doctors not only in Britain but also in many other countries, that is largely due to the personality and qualities of leadership of its director-general.

Soon after his election by the Sixth World Health Assembly in 1953 it became clear that Candau was to be a strong director-general. Its constitution provides that the W.H.O. consists of three organs: the World Health Assembly, at which official delegates from all member countries meet annually; the executive board, a much smaller body meeting twice a year, whose members are appointed by their governments but act in a personal capacity; and the secretariat, of which the director-general is the administrative and technical head. In this capacity Candau has built up over the past two decades a secretariat in which the two governing bodies have every reason to feel confidence, and he has moreover made it plain that he was not to be swayed or intimidated by the many contradictory political pressures to which any incumbent of a post of such international significance must necessarily be exposed.

Candau started with an advantage in that, as a Brazilian, he was not automatically suspect by any of the major geopolitical groups. Furthermore, his own personal objectivity in matters of international politics has never been called into question, and he has enjoyed the confidence and friendship of delegates of 135 nations of the most diverse cultures and political systems. As well as being a skilful diplomat he has steered the W.H.O. into becoming much more than an international club of public health officials. After completing his basic medical training at Rio de Janeiro, he pursued postgraduate studies in public health both in Brazil and at Johns Hopkins. He then occupied progressively important positions in the public health service of his own country, after which he became a senior official of a special co-operative health service established jointly by the Brazilian

government and the Institute of Inter-American Affairs. In 1950 he became a director of the W.H.O. and after a year was promoted to the rank of assistant director-general. In 1952 he was nominated as assistant director of the Pan-American Sanitary Bureau in Washington, which acts as the Regional Office of the W.H.O. for the Americas. It was in this capacity that he was elected director-general of the World Health Organization.

At the time of his appointment opinions were still divided on what should be the limits to the W.H.O.'s role. The more conservative felt that its proper concern should be restricted to such practical public health matters as the provision of pure water supplies, the sanitary disposal of organic wastes, and international quarantine—all traditional fields for international health action, and all of continuing importance—but that medical science in its more academic aspects should be left to Unesco and to the non-governmental Council for International Organizations of Medical Sciences (C.I.O.M.S.). In fact Unesco made representations to this effect almost 20 years ago, though it did not have at the time a single medically qualified member on its staff. In informal discussions the view was put forward that the C.I.O.M.S.—at that time having a staff of one medical officer and two secretaries—and not the W.H.O. should advise Unesco on questions of medical science, as did the International Council of Scientific Unions in respect of other branches of science. This view seemed unrealistic at the time that it was advanced, but in retrospect it is nothing short of ludicrous. In the ensuing years the W.H.O. has, under Candau's direction, become increasingly recognized as a focal point in the international co-ordination of research in such fields as cancer, cardiovascular diseases, human genetics, immunology, and virology.

In the group of organizations constituting the United Nations system the W.H.O. stands out as having been particularly effective and successful, and doctors everywhere have a right to be proud that an organization that is peculiarly their own should have been able to win such universal approbation. When Candau came to the W.H.O. it was a small organization. He leaves it as a large one, of which he has been the principal architect, and he has deservedly received honours from many.

The monument that Candau has left is an organization that has come to be universally recognized as an effective

instrument for serving the health needs of humanity. In his onerous task he has had the constant support of the deputy director-general, Dr. Pierre Dorolle, of France, who has served the W.H.O. in the same capacity under two directors-general since 1950. Dorolle also relinquishes his office this year, having been for almost a quarter of a century a veritable tower of strength for the W.H.O., bringing to bear his penetrating intellect and power of decision on a multitude of problems great or small. At the Twenty-sixth World Health Assembly, which opened on 7 May, regret at the dissolution of this fruitful partnership was widespread, and delegates of all political persuasions paid unreserved tribute to the quality of Candau's leadership. The chief delegate of the United Kingdom, Sir George Godber, endorsing the encomia of previous speakers, added that "Marcolino Candau and Pierre Dorolle, who both leave us so soon, have each personally won the respect and affection of every one of us who have represented our countries at any of these last twenty Assemblies."

The many nations represented at the World Health Assembly had the wisdom to elect as Candau's successor one who has had many years of experience of the organization, both in the field and at headquarters, in the person of Dr. Halfdan Mahler, of Denmark. Mahler's long international experience will doubtless be a priceless asset in enabling him to live up to the high standards set by his predecessors, and we wish him all success in his complex and exacting task. As for Candau and Dorolle, we can only hope that they will continue, in one way or another, to contribute to the cause to which they have so effectively devoted so much of their lives.

The Cardiomyopathies

At a recent symposium in London the International Society of Cardiology reviewed the present state of knowledge of the cardiomyopathies¹ and drew attention to issues which remain contentious. Cardiomyopathies are literally diseases of heart muscle, and despite considerable argument about definitions and classifications there are two main clinical problems in the developed countries—congestive cardiomyopathy and hypertrophic cardiomyopathy.² The evidence suggests that these are separate entities and that congestive cardiomyopathy represents the end stage of a wide range of disorders. The hypertrophic cardiomyopathies have received considerable attention,³ and the symposium was particularly concerned with the large heart of unknown aetiology usually presenting in congestive cardiac failure.

Clinical, functional, pathological, and aetiological classifications of cardiac myopathies are all to be found, and the clinician has long had to struggle to sort his way through the semantic confusion. Dr. Celia Oakley suggested that the term cardiomyopathy should be reserved for "heart muscle disorder of unknown cause or association," while heart muscle disease of known cause and association should be specifically designated—for example, sarcoid heart disease, amyloid heart disease, and so on. The proposed classification is a functional one; "systolic pump failure" replacing "congestive cardiomyopathy" and "diastolic compliance failure" replacing "hypertrophic cardiomyopathy." These terms provide a clinical and haemodynamic classification for which

there are pathological counterparts, and indeed all secondary cardiomyopathies produce systolic pump failure. Despite the logical appeal of the classification, the term "congestive cardiomyopathy" will probably remain in use, and owing to the pathologist's view of classification, noted by Dr. A. Pomerance, the "secondary cardiomyopathies" are almost certainly here to stay.

For the pathologist confronted with a large heart at necropsy the problem of classification can be extremely difficult. The term "idiopathic cardiomegaly" is used to describe the large heart, heavy in relationship to body weight, for which no cause can be found at necropsy.⁴ Most cases of idiopathic cardiomegaly present as congestive cardiomyopathy, but not all patients with congestive cardiomyopathy (systolic pump failure) have an idiopathic cardiomegaly. Before making a diagnosis of idiopathic cardiomegaly in a heart showing bilateral dilatation and hypertrophy, the pathologist has to exclude pre-existing hypertension, vascular shunts, obstructive lesions, severe anaemia, and ischaemic heart disease. On microscopy disorders such as myocarditis, haemochromatosis, and amyloid can be excluded, and Dr. E. G. J. Olsen observed that hypertrophic cardiomyopathy has a characteristic histological appearance and can be diagnosed with a high degree of accuracy. Of all these differential diagnoses perhaps the most controversial at the present time is that of hypertension.

In this symposium two pathologists (Professor M. Hutt and Dr. Olsen) explored the relationship between hypertension, hypertrophy, and dilatation. A discrepancy often exists between the clinical and functional estimates of disease (e.g., high blood pressure) and the pathological findings (hypertrophy and dilatation). In the absence of clinical information about previous hypertension the ultimate diagnosis on a patient with a dilated and hypertrophied heart at necropsy could be either idiopathic cardiomegaly or a dilated hypertensive heart. In the former case a myocardial lesion results in cardiac dilatation, with a resulting increase in muscle tension and cardiac hypertrophy. In the latter case there may have been longstanding and undiagnosed hypertensive cardiac disease, in which initial hypertrophy has been succeeded by gross dilatation.

Uganda Africans with severe essential hypertension but free of coronary atherosclerosis may continue for many years without developing cardiac failure, and Dr. J. M. Fowler told the symposium that cardiac failure in African hypertensives is rare in association with normal renal function. This situation is not as unusual as it may at first seem, and in a study of heart failure in hypertensives in London a decade ago the same conclusion was reached.⁵ The evidence from Europe and Africa suggests that failure is rarely a simple response to prolonged pressure load: the situation must usually be complicated in some additional way.

Some patients admitted to hospital with heart failure have a raised blood pressure which subsides to normal as the patient improves on specific treatment or on bed rest alone. This has been called "Sahli's Hochdruckstauung"⁶ and also reactive hypertension.⁷ In some patients this hypertension persists or recurs, and because of the frequent association between congestive cardiomyopathy and a raised blood pressure it has been suggested that most cases of idiopathic cardiomegaly diagnosed by the pathologist are a form of hypertensive heart disease in which the initiating hypertension has been clinically mild or has disappeared. And so to the great debate of the symposium, in which Dr. Celia